A REVIEW OF POTENTIAL HEALTH CARE BENEFIT PROGRAMS PROVIDED BY THE CALIFORNIA STATE TEACHERS' RETIREMENT SYSTEM

PREPARED PURSUANT TO CHAPTER 874, STATUTES OF 2000

MAY 2001

EXECUTIVE SUMMARY

In California, all aspects of teachers' health benefits are locally determined (generally through collective bargaining), including the vested benefits that active members take into retirement. Today the locally provided coverage for retired members ranges from no employer health insurance contribution to 100 percent district paid premiums for the lifetime of both the retired employee and spouse. The search for an equitable, affordable and achievable health benefit package for all retired California State Teachers' Retirement System (CalSTRS) members is an important priority for the Teachers' Retirement Board (Board) and the various education constituent groups. There is agreement that some level of health benefit coverage should be provided to all CalSTRS members to enhance retirement security. Without health insurance security, retirement benefits are not adequate to provide basic economic security.

Efforts to expand health care protection to all retired members have been underway for over three years. With health care costs for the elderly escalating, a solution for the problem must be found. The California Legislature and Governor have taken two important steps to help resolve the problem. First, Chapter 1132, Statutes of 2000 (SB 1435—Johnston) enables CalSTRS to purchase Medicare Part A for all members not eligible to receive this federal benefit without purchasing the coverage. (Most Americans are eligible for Medicare Part A without any premium cost.[1]) The legislation also established the Teachers Health Benefit Fund (THBF), which directs a portion of the employer's CalSTRS contribution to the THBF. The establishment of the THBF is an important tool in the efforts to expand other health care benefits to retired members.

Secondly, although all retired CalSTRS members could now receive Part A coverage without having to pay a monthly premium, affordable health care for all retired members is still not universally available. To identify means to resolve this continuing situation, it was recognized that the larger problem needed a fresh look at ways to solve it. Chapter 874, Statutes of 2000 (AB 2383—Keeley) directs CalSTRS to report to the Legislature on solutions and funding of those solutions. AB 2383 requires CalSTRS to evaluate and provide options for prescription drug coverage and health insurance programs for retired members. CalSTRS, with input from its Health Benefits Taskforce, has considered various retired member health care coverage plans, cost projections and administration models. This report evaluates alternatives through which CalSTRS could participate in enhancing the affordability of health care to its retired members.

This report evaluates six different health care models:

1. Provide and fund a prescription drug plan
    - Comprehensive prescription drug plan
    - Catastrophic prescription drug plan

[1] Medicare benefits are provided without payment of a premium to retired workers, and their spouses, if the worker earned 40 credits of Medicare coverage. These credits can be earned by paying the Medicare payroll tax for 10 years.

2. Fund participation by retired members in local district medical plans
3. Provide and fund statewide health benefit program for all retired members
4. Provide and/or fund local and statewide Medicare supplement plans
5. Fund individual retired member health benefit premium payments
6. Administer retirement health care security accounts (a program for active members)

Because all aspects of teachers' health benefits are locally bargained and have little in common among districts, any plans developed and implemented by CalSTRS will have important implications for local districts, active employees, and retired members. This diversity and impact has been carefully considered in relationship to each of the plans reviewed. There is agreement among all the constituent groups that some health benefits coverage should be provided to CalSTRS members, in addition to their current retirement benefits. Several of the benefit program ideas discussed in this report have broad support, although at this time, no one proposal has emerged as the unanimous first priority. The two options that appear to have developed the most interest were (1) a catastrophic prescription drug plan, which was the initial choice of most constituent groups and (2) using CalSTRS resources to fund individual retired member health benefit premiums, particularly the Medicare Part B premium. Although there was no consensus on which of these proposals should be implemented first, each group is very committed to moving forward with some health benefit program.

CalSTRS' review of the health benefit environment indicates that there is a need for specific improvements to the health benefits provided to retired CalSTRS members. In particular, the availability of affordable comprehensive care to members over age 65 is, to a large degree, dependent on the coverage provided by their former employer, which varies substantially across the state.

In light of that need, the Board recommends that the Legislature, subject to the availability of resources to CalSTRS and no increased General Fund contributions, enact legislation that

1. Establishes a prescription drug plan that covers prescription drug costs above a specified level to provide catastrophic coverage for retired members, and
2. Establishes individual nominal health benefit accounts for retired members, with CalSTRS contributions credited to the accounts to pay Medicare Part B premiums or an equivalent subsidy.

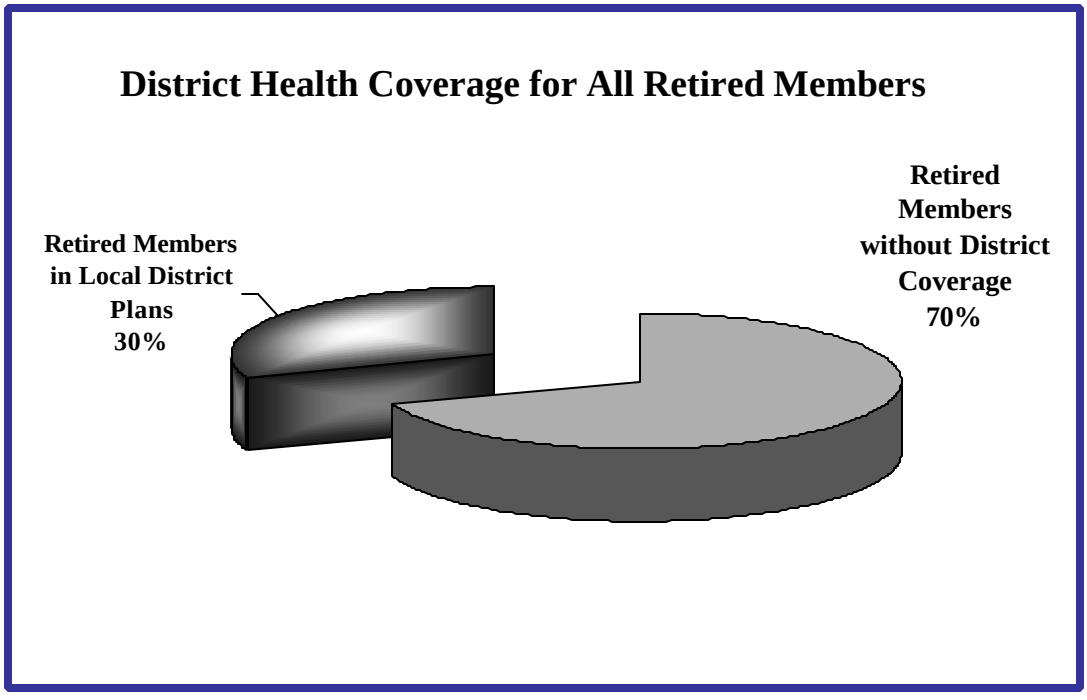
In addition, CalSTRS' review of alternative health benefit programs indicated that crediting contributions into individual nominal health benefit accounts while members are employed is a potential long-term solution to making affordable health care available to members when they retire in the future. As a result, the Board has directed CalSTRS staff to explore the legal and tax issues associated with establishing such accounts, and identify any necessary changes to federal law to facilitate development of this program.

I. RETIRED MEMBERS HEALTH INSURANCE ENVIRONMENT

CalSTRS MEMBERS WITHOUT GROUP INSURANCE

The Board was required by Chapter 928, Statutes of 1998 (SB 1528—Schiff) to conduct a study on providing health insurance benefits for CalSTRS members and their families. The Board engaged the national consulting firm of William M. Mercer, Inc. to assist in this effort, and conducted a comprehensive survey of medical, dental and vision benefits for all CalSTRS members (active and retired members). The survey was completed in the summer of 1999, with a report on the survey findings issued later that year. The CalSTRS Health Care Feasibility Study provided valuable insights into the attitudes, interests, and needs of CalSTRS members as they pertain to both health benefits and to a CalSTRS role in sponsoring or administering those benefits.

Among the findings of the feasibility study report was that over 75 percent of CalSTRS members over age 65 (and 70 percent of all retired members) receive no or a minimal contribution toward health insurance from their former education employers. Fifty-five percent purchase Medicare supplement coverage individually, and therefore do not have the advantage of group insurance benefits, which provide broader coverage. For these members, access to prescription drug coverage depends on the availability of Medicare HMOs and/or Medigap plans licensed in their area. The availability of prescription coverage has been eroded by the withdrawal of many Medicare HMOs (Medicare+Choice) from many areas of the state. Many elderly CalSTRS members are now faced with few, or no, affordable options for drug benefits. This leaves some members vulnerable to severe economic hardship if they have or develop a serious medical condition.



When prescription drug coverage is available, these plans have benefit maximums ranging between $800 and $2,000 annually. (By comparison, a Congressional Budget Office report issued in February 2001 reported that the average cost of the drugs used by a Medicare beneficiary was $1,525 per year.) In addition to these low maximums, some plans cover only generic medications even when no generic substitute is licensed or marketed.

HOW RETIRED EDUCATORS SECURE HEALTH INSURANCE

California has a tradition of locally set teacher compensation, including employee benefits (other than pension benefits). Because pension benefits are provided on a statewide basis, these benefits are generally comparable from district to district. This is not the case with other employee benefits, *particularly* health coverage. There are wide differences among districts in premiums, employer contributions, plan copay levels, covered services, and employer supported retired member medical insurance.

In 1985, the California Legislature attempted to improve the retired teacher health insurance situation with the enactment of Chapter 991, Statutes of 1985 (AB 528—Elder). This legislation required local school districts to allow retired employees to enroll in the local health care plan. There was, however, no requirement that the district contribute toward the retired employee's coverage. Even more onerous was the provision that allowed the local plan to set higher premiums for retired members commensurate with their potentially higher medical utilization.

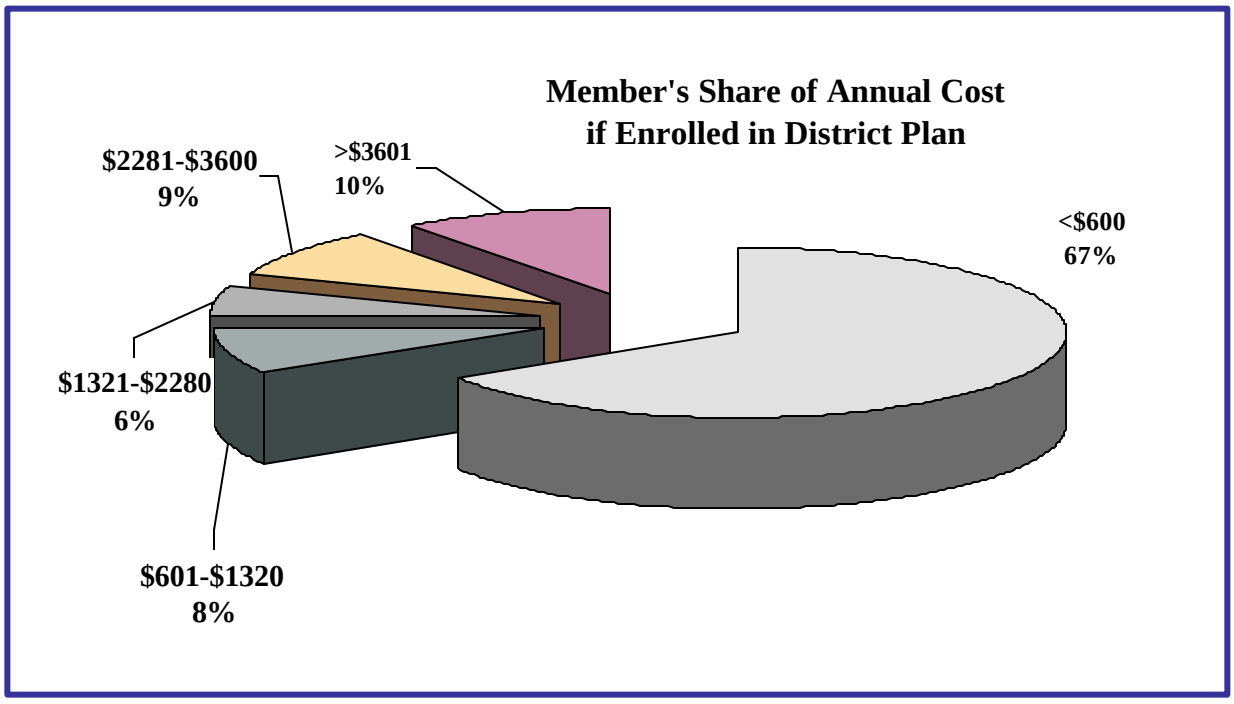
COLLECTIVE BARGAINING SUCCESS

Today, because of AB 528, when educators retire, they generally remain in the local district health plan at least until age 65. And, through collective bargaining successes, most K-12 and community college districts fund health care coverage for retired employees until they reach age 65. However, most districts do not provide any contribution toward a retired employee's medical insurance after age 65. Only a handful of the largest, oldest and most urban districts pay for full medical coverage for a retired employee's lifetime.[5]

RISING HEALTH INSURANCE COSTS FURTHER ERODE DISTRICT SUPPORT

For most districts, securing adequate resources for current educational needs makes funding medical expenses for retired employees a luxury that neither the bargaining groups nor the districts can accept. It is common to hear district leaders say, “Paying for health insurance for retired employees spends current education dollars on previous education services.” As health insurance premiums are again rising at double-digit levels, districts are increasingly unwilling to accept (or

[2] See Appendix Three. District Provided Retiree Health Coverage.



extend) the long-term liability that health insurance for retired employees represents. For those districts that do provide health coverage for retired employees, the benefit is a growing fiscal burden. Because of the increasing financial strain, some are actively considering substantial modification to the benefit for employees who retire in the future. As the number of retired employees increase, many local district health insurance programs have as many as one or more retired employees for every current employee. These plans are seeing dramatically escalating medical costs and few options to mitigate these rising expenses. It is quite possible that increasing medical insurance costs will erode some districts' ability to meet other important needs. At the very least, this situation will affect many districts' ability to allocate additional dollars for other aspects of compensation.

CalSTRS HEALTH BENEFIT INITIATIVES

When CalSTRS initiated its review of health benefit needs of CalSTRS members in 1999, the Board established the Health Benefits Committee to assess the scope and breadth of CalSTRS members' health care coverage needs. In addition, the CalSTRS Health Benefits Taskforce, comprised of constituent group representatives, Board members (specifically the State Controller and the State Treasurer) and CalSTRS staff, was created to assist in evaluating the many aspects of a comprehensive and fiscally sound health benefit program. With the cooperation of the taskforce, CalSTRS has worked for nearly three years evaluating the administrative and financial structures of various health care coverage and delivery designs. The taskforce has played a crucial role in guiding the development of health care benefit initiatives and in building a cooperative and beneficial partnership among varied stakeholders.

CalSTRS MEDICARE BENEFITS PROGRAM

In its initial review of health benefit needs, CalSTRS identified the lack of affordable access to Medicare Part A (Hospitalization) coverage as having a significant impact on many retired members. As a result, in 2000, the Board sponsored legislation to establish a new benefit program that provides all CalSTRS retired members the opportunity to participate in Medicare. Chapter 1132, Statute of 2000 (SB 1435—Johnston) enables CalSTRS to pay Medicare Part A premiums (and any associated penalties) for those retired CalSTRS members who are not eligible for premium-free Medicare Part A.

This new benefit assures that all California educators have the financial ability to participate in Medicare Part A by eliminating cost as a barrier. The program, currently limited to CalSTRS members retired before January 1, 2001, may be extended to qualified members who retire in the future. This means that California teachers can have the same minimum level of retirement health care protection as most other Californians who have Medicare eligibility.

By committing a portion of resources available to CalSTRS for this purpose[3], the Board, the Legislature and the Governor have demonstrated a willingness to use resources available to CalSTRS to implement solutions to ease the burden of rising health care costs for retired members. Yet, it is not possible for CalSTRS alone to meet all the health benefit needs of its members. A truly universal, comprehensive health benefit for retired educators will require additional funding sources in the form of premiums or additional contributions from members, employers and/or the state.

THE MEDICARE ENVIRONMENT IN 2001

The Medicare program has been the essential health insurance protection for America's elderly since it was signed into law in 1965. Although Medicare is the fundamental financial base of elderly medical coverage, Medicare coverage has not always kept pace with recent strides in medical technology and resulting changes in clinical practice. As a result, Medicare does not pay for the preferred treatments in some important areas.

For example, medication currently is the only treatment for many conditions. Yet, Medicare continues to exclude outpatient prescription drugs from its coverage. Consequently, seniors who rely on Medicare as their health insurance plan must pay for prescription drugs on their own. There are private insurance plans (Medigap and Medicare HMOs) that do provide limited drug

Medicare HMOs & Medigap premiums are increasing at nearly 20 percent a year.

Much of these costs result from rising prescription costs.

[3] The Medicare Benefits Program is funded by redirecting employer contributions that otherwise would be credited to the Defined Benefit (DB) Program (the main pension program administered by CalSTRS) to the THBF, a special trust fund that is available only to pay health benefit expenses. The resulting reduction in contributions to the DB program is mitigated by resources that are in excess of the amount needed to fund DB Program benefits. There is no use of pension trust funds to support the health benefit program. Health benefit programs identified in this report that would be funded with CalSTRS resources would be similarly funded.

coverage. These plans' premiums, however, are often very expensive. Moreover, in some areas of California the coverage is not available at any price[4].

To compound the problem, a recent Kaiser Family Foundation study found that the prices seniors pay for their prescriptions are frequently higher than the price paid by younger or better-insured Americans. Seniors, who must buy their prescriptions at retail if they do not have prescription drug insurance, do not benefit from negotiated price discounts or bulk-buying price advantages that most insurance companies and group plans enjoy. Faced with often-unaffordable drug prices, studies are documenting that many elderly Americans do not comply with their doctors' directions. These seniors employ a variety of practices to "stretch out" the medication to save money. These include taking smaller doses than prescribed, "sharing" prescriptions with spouses or friends, and simply not filling the prescription at all. Until prescription drugs are included in Medicare, a very big gap will remain in protecting America's elderly from potentially devastating medical expenses. Given the bipartisan interest in this issue, it is likely that the federal government will eventually take some action. Until that happens, however, many CalSTRS members, without group insurance protection, are being placed at both financial and medical risk.

In addition to the coverage Medicare provides for prescription drugs, the future of Medicare itself currently is the focus of considerable debate by the federal government. Overall, Medicare spending is expected to double over the next 20 years, due to the growth in covered beneficiaries[5]. The Congressional Budget Office estimates that, by 2025, Medicare expenditures will increase to $10 trillion. Advances in medical technology, growth in the number of beneficiaries, the rising age of Medicare participants and increased patient demand will continue to push per capita costs higher.

During the recent presidential campaign, both major party candidates identified Medicare prescription drug coverage and the general restructuring of Medicare as two of the most important issues to be tackled by the new Administration. Nonetheless, in early 2001, it is unclear whether any agreement on how to tackle either the prescription drug issue or the long-term Medicare funding issues will emerge soon.

[4] See Appendix Three. Medigap Premiums in California. Medicare+Choice Plan Service Areas

[5] Congressional Budget Office Report: Long Term Budgetary Pressures & Policy Options, March 1997. Testimony on Budget & Economic Outlook: Fiscal Years 2002-2011. January 2001.

II. MINIMUM SERVICE REQUIREMENTS AND FUNDING SOURCES

The consideration of minimum service requirements and funding possibilities are important components of any health benefit program that is adopted. The decision to add any additional health programs to the package of CalSTRS benefits depends on the cost projections of such programs. Because health care costs are increasing at a rate nearly three times that of prices in the broader economy, long-term funding viability is an essential consideration. The number of CalSTRS members participating in any specific benefit will also have a direct impact on the benefit's cost. Ultimately, the adoption of any of the models presented in subsequent sections will depend on the confidence the Board, the Legislature and the Governor have in the reliability of the cost projections and the dependability of the financing sources.

MINIMUM SERVICE CREDIT ISSUES

KEY POINTS

- Full access to CalSTRS-supported health benefits should be for career educators.
- A graduated vesting scale would provide limited support for members with shorter careers.

The Board's goal in evaluating health benefits was to enhance the retirement security for *career educators*. A minimum service requirement for this benefit is consistent with this goal and has wide support from the constituent groups.

Currently there are a number of retirement benefits that do require specific minimum levels of credited service in order to meet eligibility requirements. This is often referred to as "cliff-vesting", in which a member who has less than the minimum amount of service receives no amount of a specific benefit. However, whenever receipt of a benefit is contingent on receiving a specific minimum level of service, issues inevitably are raised concerning members whose credited service is just below the required amount. For example, a member who is not paid for one day of a school year, for a variety of reasons, may not be eligible for a variety of benefit enhancements without teaching into another school year.

In addition, because California schools and colleges are seeking mid-career professionals to enter teaching, interest in extending the benefit to members with shorter careers is growing. Retirement health benefits could be an additional recruiting tool for this population. A graduated funding schedule, with the amount of the CalSTRS benefit based on a schedule of increasing credited service, would be an alternative to the cliff-vesting and has the support of the constituent groups.

---

[6] See Appendix Three. District Provided Retiree Health Coverage.

This graduated mechanism would continue to reward those with long careers at a higher level without creating some of the issues that exist in other benefits that have utilized the cliff-vesting system. Finally, a graduated benefit schedule makes it more feasible to establish a higher threshold for complete benefits. If a full benefit is provided after relatively little service, it is less important to provide a graduated schedule of benefits. However, any expansion of eligibility standards, which would provide coverage to additional members, would necessarily increase the cost of this benefit.

The table below shows a possible graduated vesting schedule based on a benefit payment of $50 per month.

POTENTIAL GRADUATED BENEFIT SCHEDULE

LENGTH OF SERVICE	50% BENEFIT PAYMENT	75% BENEFIT PAYMENT	100% BENEFIT PAYMENT
10 years	**$25**		
20 years		**$37.50**	
25 years			**$50**

FUNDING SOURCES

KEY POINTS

- CalSTRS' current resources do not permit the system to fund 100 percent of a comprehensive health benefit program for all current and future retired members.
- The member, the district, and the State all have an interest in supporting health benefits for CalSTRS retired members.

The goal of assuring that all CalSTRS retired members have health security can be achieved when retired member health benefits are equalized throughout California. When the Board, the CalSTRS' constituent groups, and staff began the health benefit initiative, there were many anecdotal stories regarding the scope of the problem but limited quantifiable information. Now there is documented information on the health benefit needs and interests of CalSTRS members. Only 10 percent of local districts provide retired employees health insurance funding after age 65. While there are currently wide differences among the retirement health benefits of members, over time these differences can be reduced with support from all stakeholders.

There is unambiguous support for enhanced retired member health care benefits from the constituent groups. There is, however, less clarity regarding which benefit plans should be adopted and how CalSTRS financial and administrative resources should be committed. If the only resources available for this initiative are CalSTRS funds, the alternatives that can be funded will be limited,

and the implementation of such initiatives will be delayed until such funds become available. Yet the other stakeholders, the state and districts, also have a compelling interest in enhanced retirement benefits for educators because these benefits will support recruitment and retention efforts that are key to overall improvement of California's public schools.

PAYING FOR CalSTRS RETIRED MEMBER HEALTH BENEFITS

The report identifies the currently estimated present value of the individual alternatives over the first 10 years of the program. Typically, when CalSTRS evaluates proposed benefit enhancements in its pension program, it estimates the present value of cost over the first 30 years. The economics of health care, particularly the volatility of health care costs, however, make projections beyond 10 years not particularly meaningful. As a result, the long-term costs of the individual alternatives are identified only for the first 10 years. This does not, however, reflect the length of time that CalSTRS anticipates the alternative benefit would be provided. Moreover, it does make comparing the cost of these benefits to pension benefits more difficult.

In addition, because health care costs are so volatile, CalSTRS may determine it fiscally necessary to limit its financial participation to a fixed amount in order to protect the fiscal integrity of the overall retirement system. By establishing a defined amount available for each health benefit, CalSTRS will not encounter unexpected pressure to increase contributions in the future. If, however, the cost of medical care continues to increase at its historical pace, the fixed contribution amount will result in diminished protection and benefit for the retired member. Over time, additional financial contributions will be necessary to maintain the same level of benefit for the participants.

In addition, the ability of CalSTRS to provide resources for new benefits, including the benefits indicated in this report, has changed. Since 1998, the benefits provided by CalSTRS to members of the DB Program have increased significantly and the contributions required from the state have decreased significantly. These changes were made possible by CalSTRS' extraordinary investment returns during the 1990's and the impact of an improved economic environment on DB Program costs. The current economic environment is much more uncertain, and future CalSTRS investment returns may be substantially lower than in previous years. This situation obviously has an impact on the availability of CalSTRS funds for any benefit enhancements. If investment performance improves to permit CalSTRS to utilize its own resources to fund health benefits, CalSTRS financial support can be a major component of a program to provide affordable health care security to retired educators. But, ultimately, without the other stakeholders in California's education system joining in these efforts, CalSTRS members will face the possibility that their retirement income will not be adequate to meet their medical costs.

The following table lays out some of the immediate value each stakeholder could derive from participating in the establishment and funding of a system of universal retiree health care for public school and community college educators.

BENEFIT TO STAKEHOLDER IN CONTRIBUTING TO PROGRAM FUNDING			
CalSTRS Members	Maximizes personal retirement security	Maximizes buying power with tax advantaged benefits	Expands insurance by assuring group plans available
CalSTRS Board	Increases retirement security for members	Allocates excess resources to expanded benefits	Demonstrates Board's responsiveness to member needs
Districts	Promotes benefit parity among districts	Eliminates retirement health as an retention issue	Transitions districts to a fixed retired member medical benefit
State of California	Eliminates retiree health as an issue for recruitment	Recognizes the value of career educators	Demonstrates the importance of career educators

III. POTENTIAL HEALTH BENEFIT ALTERNATIVES

Pursuant to the direction given in AB 2383, CalSTRS evaluated six different alternatives for supporting and/or providing health benefits for retired CalSTRS members. They are

1. Provide and fund a prescription drug plan;
   a. Comprehensive prescription drug plan
   b. Catastrophic prescription drug plan
2. Fund participation by retired members in local district medical plans;
3. Provide and fund statewide health benefit program for all retired members;
4. Provide and/or fund local and statewide Medicare supplement plans;
5. Fund individual retired member health benefit premium payments;
6. Administer retirement health care security accounts;

Each of these alternatives is discussed in this section.

PROVIDE AND FUND A PRESCRIPTION DRUG PLAN

The CalSTRS Health Care Feasibility Study cited prescription drug coverage as the benefit plan most often identified as a priority for retired members. This is consistent with the interests and concerns of older Americans across the country. Under this alternative, CalSTRS would sponsor and contract for the administration of prescription drug coverage. Two different levels of coverage are possible: (1) a comprehensive plan for members who have no other prescription drug coverage or (2) a catastrophic plan that covers all members and pays benefits when drug costs exceed specified levels.

A statewide comprehensive or catastrophic prescription drug plan would provide those members without district-paid medical insurance protection from the runaway costs of life saving medications. Such plans would also provide CalSTRS members with affordable drug insurance not usually available on an individual member basis.

> Both prescription drug plans will reduce local plan health care costs.

The California insurance market has few insurance companies that sell a comprehensive prescription drug benefit to older applicants. The Medigap and Medicare HMOs that do provide prescription drug benefits have limits on the amount of the benefit and often on the drugs that are covered by the plan. This coverage is generally very expensive and not available in all areas of the state[7]. Because district-provided health insurance that is provided to most retired employees until

[7] See Appendix Two. Medigap Premiums in California. Medicare+Choice Plan Service Areas.

age 65 includes prescription drug coverage, CalSTRS retired members over age 65 are most likely to be those members without comprehensive or catastrophic drug coverage.

KEY POINTS

- Feasibility Study identified prescription coverage as a high priority.
- Sixty percent of CalSTRS retired members purchase individual health insurance, not paid nor supplied by the local districts.
- Catastrophic coverage for prescriptions is not available on an individual basis in California.
- Prescription plan management would be less complex than other medical benefits. CalSTRS could contract with several proven prescription drug administrators.
- As many as 30 percent of CalSTRS over-65 members will have prescription drug costs greater than $1,800 in any year.
- Catastrophic prescription drug benefits are more easily adjusted in order to maintain the fixed funding commitment.

ISSUES TO CONSIDER

- Deferring action on prescription plans until federal plans are clearer.
- Prescription costs are the fastest growing medical expense. Long-term costs are difficult to predict. Plan costs could outgrow available resources. This would require the Board to either reduce benefit levels or increase the amount of resources available to the program.

Comprehensive Prescription (COMPRX) Plan. This voluntary plan would provide the primary prescription coverage for the member. The plan could have various copayment and deductible options. A member would not likely have, or need, any other prescription coverage. Premiums, deductibles, and copays would be adjusted to keep the cost of the plan to CalSTRS within the contribution commitment.

COMPRX

Would include a wide array of copayments and deductibles to meet the needs of more members.

Universal Catastrophic Prescription (UNIVRX) Plan. This plan would cover all retired members and each would be expected to maintain other coverage in an underlying plan. The plan deductible would be high (i.e. $1,200-$2,000 per member). The amounts paid by both the member and the underlying plan would apply toward the deductible. After the deductible is met, a small copayment (i.e. $10) would be required up to an established maximum (i.e. $7,000). Deductibles and copays would be adjusted to keep the cost of the plan to CalSTRS within the its financial commitment.

[8] See Appendix Three. Districts Contributions toward Retired Employee Health Insurance.

Plan Cost Estimates: Projections of prescription drug plan costs prepared by Milliman & Robertson, CalSTRS' consulting actuary, assume that costs will escalate at more than double the medical inflation rate and nearly five times the current overall Consumer Price Index. Although these estimates are realistic based on the information available at this time, potential changes in both medical practice and law (such as new pharmaceuticals in the pipeline and breakthrough treatment of chronic disease that call for 'drug cocktails') could have a profound effect on the cost of prescriptions for seniors in the out years.

UNIVRX

The catastrophic prescription plan would cover all retired members even those currently enjoying district provided coverage.

On the other hand, unforeseen events and developments (such as Medicare prescription drug coverage, federal drug cost controls and expansion of over-the-counter drug availability) could reduce the rate of price increases and result in drug costs lower than projected. This could reduce the member's out-of-pocket exposure and the sponsor's funding obligation.

Relying on prescription cost projections beyond 5 years is not practical in today's environment.

Both drug plans contemplate limiting CalSTRS' financial exposure to a fixed amount through planned benefit changes in the future, such as adjustments in the deductible level, copayment structures and member premiums (if applicable). These adjustments, while maintaining CalSTRS' contribution costs within the defined commitment, would result in a declining level of coverage.

The plan design would have automatic increases in the member's cost share built into the initial plan benefits. The deductible, copay, and/or threshold at which CalSTRS would provide complete coverage would rise by 5 to 10 percent every two years. Although the Board could choose to amend the plan and not implement a cost share increase if costs were lower than projected, members would have an understanding of the cost share increases and those increases would be predictable. If plan deductibles and copays are not adjusted biannually, the projected 10-year cost of the *catastrophic* plan will rise from $766 million to approximately $1.1 billion if all retired members participated in the program.

Both prescription plans would maximize the use of the latest innovations in prescription drug cost control and quality assurance systems. Each plan would include a patient-focused disease intervention program to help members manage their medications appropriately and to help with overall life skills for the chronically ill. The *comprehensive* plan would incorporate a broad formulary.

Future benefit modifications would be built into the plan design.

Benefit adjustments assure that costs remain within commitment.

CalSTRS contribution is defined in advance.

Even with these elements, it is difficult to project actual plan costs beyond the first four or five years of operation. Based on actuarial work of both William Mercer, Inc. and

Milliman & Robertson, Inc., the cost of a *comprehensive* drug program covering only those members without district paid coverage is estimated at nearly $1.5 billion over ten years. Members would pay some of the costs through premiums, deductibles and copayments. In order to minimize the chance that only members with high prescription costs (adverse selection) will participate, the benefit contribution by CalSTRS or other public entities must approach two-thirds of the total cost, or $1 billion over 10 years.

If all retired CalSTRS members, including those with district-paid retirement health insurance, participated in a *comprehensive* prescription drug plan, the program costs are estimated to exceed $2.5 billion over the same period. The local plans that provide health coverage to retired employees could expect to see a reduction in their health costs of approximately $300 million when this plan is fully implemented.

Over time, a CalSTRS *Comprehensive* Prescription Drug Plan could expect to have approximately 100,000 participants (members and dependents). Use of this benefit would be high because of the ages of the members. Based on 1999 data, the average member would have 18 prescriptions per year[9] and the median price of each prescription would be nearly $62 or approximately $1,100 in prescription costs annually.

The *Catastrophic* Prescription Drug Plan would immediately include all retired members, resulting in about 200,000 covered members and dependents. CalSTRS would pay most plan costs for the member, except for reasonable copayments. Premiums would be required for dependent participation.

Because the *catastrophic* drug plan would integrate with members' individual Medigap and Medicare HMOs plans, there would be no overlapping of prescription drug coverage resulting in over-insurance for this group. However, for

UNIQUE VALUE FOR THE MEMBER

The CalSTRS prescription plans would have specific features valuable to an older population.

The plans would emphasize quality of life services.

- Case Managers and Disease Intervention.
- Patient & Member Education Programs.

The Catastrophic Plan would have strong market presence with 200,000 retired members and dependents.

Local plans could be expected to modify retired employees' prescription benefits.

[9] Express Scripts 1999 Drug Trend Report, June 2000, Express Scripts 2000 Report on Prescription Drug Usage in the Insured Senior Population. November 2000. February 2001 Congressional Budget Office set the annual amount at $1,525 or 39 percent increase over Express Scripts study.

members in local district plans, a universal catastrophic prescription drug plan would result in over-insurance.

To avoid this duplicate coverage, CalSTRS anticipates that local district plans would amend the drug benefit for **retired employees only** by establishing an annual prescription benefit maximum. This benefit change would provide value by (1) eliminating potential over-insurance of the group of retired employees and (2) helping local plans' reduce the cost of retired employee medical coverage.

Local plans could save as much as $400 per retired member the first year the Catastrophic Plan is in place.

Most local plans subsidize premiums for retired employees to a minimal extent by blending the experience of active and retired groups and then setting a common premium structure. A *Catastrophic* Prescription Drug benefit would limit the local plan's drug cost exposure for retired employees and should have a positive impact on the plan's overall experience and ultimately the active employees' premiums. Local plan savings are estimated to be nearly $400 per retired member per year.

PBMs are the most automated administrators in health care.

Prescription data collection is reliable and timely.

Both costs and use can be monitored accurately for appropriate utilization of all medications.

Administrative Considerations: For CalSTRS, becoming a plan sponsor of any health program will be a major new responsibility. If, however there is an area where the administrative issues would be the least complex, it is in the area of prescription coverage. Drug benefit administration is the most automated area of health care. It also has the best data capture systems and reporting standards. CalSTRS should be an attractive potential client for several experienced and well-regarded pharmacy benefit managers (PBM) that could administer the program either initially or on a long-term basis.

ILLUSTRATIVE BENEFIT DESIGN **COMPREHENSIVE PRESCRIPTION DRUG PLAN (COMPRX)**			
Annual Deductible	$0	$50	$100
Copayment	$10/$20	$10/$25/$35	$8/$15/$30
Mail Order Mandatory	Optional	After 90 Days	After 90 Days
Local Prescription Drug Network	Yes	Yes	Yes
Mandatory Generic	Yes	Yes	No
Case Management	Yes	Yes	Yes
Formulary	No	Yes	Yes
Total Cost Per Member per Month, 07/1/01	$145	$115	$75
Member Premium, (cost share under 33%)	$42	$29	$15
Maximum Benefit	None	None	None
Estimated 10-year Plan Cost, 15 Years of Service	$1,885 million	$1,652 million	$1,281 million

Any voluntary health benefit program can result in a pool of participants with higher medical expenses than the overall population of that age group, a situation referred to as "adverse selection". This usually occurs when the member's share of the cost is too high. If only members who are confident that their prescription costs will exceed the cost of the plan elect to participate, cost projections will be significantly understated and overall plan viability will be in question. The plan's member out of pocket expenses, such as deductibles, copays and premiums, should be limited to no more than one third of total plan costs. This level of cost share can be accomplished through both the group purchasing and the CalSTRS member benefit.

The *Catastrophic* Prescription Drug Plan, unlike the *Comprehensive* Prescription Drug Plan, would integrate with the member's underlying drug plan. As such, this plan would not include a formulary. This would prevent those members whose base prescription drug coverage rolls to the CalSTRS plan from encountering formulary incompatibility between the two plans.

The universal eligibility feature eliminates the adverse selection concern of the Comprehensive Prescription Drug Plan and can be expected to have drug utilization very similar to projections. Finally, with the adoption of a Catastrophic Prescription Drug Plan all similarly situated members will have the same CalSTRS benefit regardless of the district from which the member retires.

Catastrophic Prescription Drug Plan would **not** have a unique formulary.

The transition from the underlying plan to the CalSTRS plan would be seamless for the member.

ILLUSTRATIVE BENEFIT DESIGN **CATASTROPHIC PRESCRIPTION DRUG PLAN**			
Annual Deductible	$1,200	$1,800	$2,000
Co-payment	$10	$10	$10
Mail Order Mandatory	Required	Optional	Optional
Local Prescription Drug Network	Yes	Yes	Yes
Generic Mandatory	Yes	Yes	No
Case Management	Yes	Yes	Yes
Formulary	No	No	No
Total Cost Per Member per Month, 07/1/01	$50	$35	$25
Member's Share of Cost	$0	$0	$0
Copay Waived	After $7,000	After $7,000	After $7,000
Maximum Benefit	None	None	None
Estimated 10-year Plan Cost, 15 Years of Service	$650 million	$512 million	$427 million

FUND PARTICIPATION BY RETIRED MEMBERS IN LOCAL DISTRICT MEDICAL PLANS

Under this alternative, CalSTRS would contribute a predetermined fixed amount annually toward the retired member's costs in the local plan. CalSTRS' role would be to help support the individual retired member's costs to remain covered by the local district benefit plan. This option would maximize the value of the current system of local health benefit plans.

KEY POINTS

- A contribution on behalf of the retired member to the local district plan would reward those districts that have provided health insurance to retired employees.
- Providing a benefit for the retired member to remain with the local plan may encourage benefit plans particularly designed to integrate with Medicare—such as true supplement plans and Medicare HMOs.
- Would maximize the administrative capabilities that already exist at the local level.

ISSUES TO CONSIDER

- Health benefits will not be uniform for all retired members.
- Some members may not have the local plan available because they no longer reside in the same community from which they retire.

Annually, the district plan sponsor would provide CalSTRS with the names of members enrolled in the local plan. CalSTRS would then remit to the plan sponsor an amount equal to that year's payment for all local participants.

The Context of the Local Plan Payment: Ninety-nine percent of all full-time active members have health insurance coverage provided by the school district or the community college district. Currently, nine out of ten K-12 districts and community colleges contribute toward the health insurance premiums of their retired employees who are under age 65. It is common for that contribution to be on the same basis as the district contributions for active employees. Less than 20 of California's districts, however, provide an equal contribution for the lifetime of a retired employee.

Unfortunately, many local plans discourage retired employees who are over age 65 from remaining in the district plan by not offering a true Medicare supplement health plan. As a result, a retired employee can often purchase individual Medicare supplemental coverage less expensively than the local plan premium. There is a serious unintended consequence of this lack of accommodation for retired employees. Because the individual plans have significant prescription drug limitations and often-onerous medical underwriting requirements, retired employees most in need of comprehensive prescription coverage or unable to pass the underwriting requirements remain in the local plan. This further drives up the claims costs and premiums of the group of retired employees. It is a classic example of underwriting rules resulting in a continually increasing employer cost.

Because of these considerations, a CalSTRS premium contribution on behalf of individual retired members to local district plans could have two valuable and complementary benefits. They are (1) all retired members, both the healthy and unhealthy, would be encouraged to remain in the local plan throughout retirement and (2) a larger, more diverse pool of covered retired members should be a better underwriting risk resulting in lower per capita premium rates. This environment should also encourage local plans to design benefit structures to coordinate with Medicare. Overall, such a plan could be expected to produce competitive local plan premiums for retired employees and comprehensive coverage packages.

Due to some geographic limitations, retired members who do not reside in an area where the local district plan provides coverage would be without an option.

8 out of 10 retired members have district-paid health insurance until age 65.

Some districts have rules intended to protect the local plan from retiree costs, yet these rules have contributed to cost spiral.

The plan cost would be predetermined and would be the basis for the individual member benefit.

Predefined criteria could determine how the benefit would be modified.

Plan Cost Estimate: The cost of this program is entirely dependent on the amount of premium support by CalSTRS determined to be necessary, adequate and affordable. A fixed dollar annual or monthly contribution set in 2001 would surely be judged inadequate in 2015. As a result, a mechanism to adjust the contribution over time would be an important plan feature. The most costly benchmark would be one indexed to either medical cost inflation or health insurance premiums.

Members could be expected to seek increases in the benefit as health care costs drive up premiums and copays.

Adequate administrative start up funding for CalSTRS would be approximately $750,000, including modifications to information systems, which should not be substantial. On-going administrative costs would be minimal. Initially, an outside administrative contractor could operate the plan until the necessary information system platform is in place.

Plan Design: Under this proposal, the individual district would notify CalSTRS annually of the number of retired members enrolled in the local plan. CalSTRS would pay the amount in arrears for each verified eligible participant to the local district plan sponsor. The districts would be required to use the payment **only to reduce a retired employee's** out-of-pocket cost, such as the retired employee's portion of the premium, or to reduce required copayments, or to provide additional benefits.

The member subsidy would be based on a pre-established overall program cost.

Supporting further development of retired member benefits at the local district level would maintain the strong connection many retired employees have and many more would like to enjoy with their former colleagues and education community.

ILLUSTRATIVE BENEFIT DESIGN

SUBSIDIZED LOCAL PLAN PARTICIPATION

Annual payments to districts in arrears

Districts required to use funding only to reduce retired member out-of-pocket costs

Annual or biannual setting of benefit amount to be payable for each retired member

PROVIDE AND FUND A STATEWIDE HEALTH BENEFIT PROGRAM FOR ALL RETIRED MEMBERS

Under this alternative, CalSTRS would be a provider of health benefits to all retired CalSTRS members, including those under the age of 65, and provide financial support of the premiums paid by eligible retired members.

Establishing a health plan for all retired members has generated little interest.

A statewide plan for all retired members would be the most expensive, unwieldy and difficult health benefit to implement and operate for retired members. Health plans for all retired members in other states have increasingly been restructured because of escalating medical costs[10]. These plans are becoming unaffordable for both the beneficiaries and the sponsoring public agency. There has been little constituent group interest in this approach.

KEY POINTS

- A plan specifically designed for retired members should meet the unique needs of older members more effectively than plans designed primarily for younger, active members.
- Health benefits would be uniform for all retired members.

ISSUES TO CONSIDER

- A plan for all retired members would be complex and expensive to administer.
- Retired members who benefit from blended (actives and retired employees) rates in a district plan could lose the value of that indirect subsidy.
- The statewide plan would create yet another health care administrative structure.

Plan Cost Estimate: A statewide plan for all retired members would be the most expensive, unwieldy and difficult health benefit to implement and operate for retired members. Health plans for all retired members in other states have increasingly been restructured because of escalating medical costs[11]. These plans are becoming unaffordable for both the beneficiaries and the sponsoring governmental agency. Since there has been very little interest in moving forward with this approach, the cost analysis relies on the published experience of comparable populations.

The annual costs for the group age 65 and over, including a comprehensive prescription drug plan would be approximately $216 million based on 120,000 participants the first year. The annual cost for the group under age 65 is

States that have traditionally sponsored such plans are searching for ways to mitigate run-away costs.

[10] See Appendix Four. Other States Health Care Funding Practices.
[11] See Appendix Four. Other States Retired Educator Medical Benefits.

estimated to be $252 million based on 60,000 participants. A rough estimate of the 10-year cost of the program is $7.3 billion. If member premiums offset 50 percent of the program cost, the CalSTRS portion would be $3.6 billion during the 10-year period.

PROVIDE AND/OR FUND LOCAL AND STATEWIDE MEDICARE SUPPLEMENT PLANS

Under this alternative, CalSTRS would provide and financially support a health program that supplements the coverage provided by Medicare. This plan would be available only to retired members who are at least age 65. The plan would also include a prescription drug benefit.

Members without vested lifetime insurance could choose to remain in the local district plan or to participate in a statewide CalSTRS Medicare supplement plan. In either case, some portion of the member's premium would be subsidized.

Members with district-provided lifetime coverage would have a CalSTRS benefit payment made on their behalf to the district plan sponsor. This payment could only be used to offset any member paid costs.

The Statewide Medicare Supplement Plan would be designed specifically to meet the unique needs of older members.

This plan would enable each retired member enrolled in Medicare to choose to participate in either the local district plan or a CalSTRS sponsored statewide plan providing Medicare supplement coverage.

KEY POINTS

- The plan would be designed exclusively for members and eligible dependents with Medicare Parts A & B. This is the group least likely to have district-supported health coverage.
- Medical care costs of a plan that covers only members with Medicare would be easier to predict and more affordable than a plan that included retired members without Medicare.
- Each retired member would have the option of selecting Medicare supplement coverage through the local district plan or the statewide CalSTRS plan.

ISSUES TO CONSIDER

- A statewide plan would create yet another health care administrative structure.
- The statewide plan would take several years to fully implement.
- CalSTRS does not have experience in health plan sponsorship.

Plan Cost Estimate: The administrative cost to launch this plan could run as high as $1.5 to $2 million. This includes all administrative and communication (an important aspect of the plan's success) expenses associated with the establishment of the plan. The California Public Employees'

Retirement System (CalPERS) spent nearly that amount when changing plan administrators for the self-funded CalPERS plans.

The development period would require expenditures for member setup and enrollment, proposal solicitation and evaluation from administrators, health plans, and insurance companies. Establishing a statewide Medicare supplement health plan (including prescription drugs) would require 24 to 30 months to complete. Realistically, therefore, the statewide plan could not be operational before January 2004.

Administrative set-up costs could be as high as $2 million dollars.

Ongoing administrative costs for the statewide option would be incorporated into the premium structure. Actual plan benefit costs would be determined based on incurred health care expenses, negotiated premiums for insured plans, excess loss insurance coverage and the number of participants. The size of the plan should present an attractive business opportunity for many managed care and insurance companies contributing to competitive premium structures.

The statewide Medicare supplement plan would include unique features particularly designed for older members.

Administrative costs to provide the financial support for the local option would be minimal[12]. Some information systems modifications would be required, but these should not be substantive. Initially, an outside administrative contractor could operate the plan until the necessary information system platform was in place.

Statewide Medicare supplement plan can be expected to experience standard underwriting risk. Claims cost should be predictable.

The plan should have standard underwriting risk because (1) the pool would be broad and diverse; and, (2) premiums and benefits would reflect both the value of large group buying power and the benefit payment. By designing the plan to attract a diverse group of members, adverse selection can be minimized.

With Medicare as the base coverage, overall claims costs should be both predictable and manageable. The plan costs over the first 10 years could be expected to exceed $2.5 billion, based on an enrollment of 60,000 CalSTRS retired members and their dependents. The CalSTRS share of that cost would be determined based on the adopted CalSTRS benefit. If CalSTRS funded 33 percent of the cost, the 10-year cost would total about $800 million.

Each member would have a premium contribution required.

[12] See Appendix One. Local Plan Subsidy. Plan Cost Estimate.

The CalSTRS benefit payment to reduce each member's premium could be established at the benefit's inception, thereby establishing a fixed CalSTRS contribution for the benefit. This fixed contribution per member could be modified from time to time by the Board subject to member needs and the availability of resources.

Plan Design: The statewide plan would be specifically designed to meet the unique needs of Medicare participants and an elderly population. As such, the plan should attract strong participation. The plan could initially be limited to medical and prescription drug benefits. In future years other benefits, such as dental coverage, could be added. CalSTRS could choose to enter into contracts with third party administrators, health plans, insurance companies or CalPERS to act in either an administrative capacity or to assume the underwriting risk.

Statewide Medicare supplement plan would be designed to include a full array of services of particular benefit to an older population.

Members would have the choice of staying in the local plan.

Members without lifetime health insurance could choose to remain in the local district plan or to participate in a statewide CalSTRS Medicare supplement plan. In either case, CalSTRS would offset some portion of the member's premium.

Members with district provided lifetime coverage would have a CalSTRS payment made on their behalf to the district plan sponsor. This payment would be used to offset any member paid premiums. If the payment was greater than the required member premium, the balance could be used to reduce other out-of-pocket expenses for which the retired member may be responsible. These payments would help control long-term member costs.

Plan Design Table:

ILLUSTRATIVE PLAN DESIGN **STATEWIDE OR LOCAL PLAN OPTION**	
Local Plan	**Statewide Plan**
Benefits & Administration Defined by Local Decision Makers	The plan would include at least all of the following: ▪ Fee-for-Service Medicare supplement ▪ Either Insured or Self-Insured ▪ Two – Four Medicare+Choice HMO Plans ▪ One – Two HMO Medicare Supplement Plans (plans not contracted w/HCFA for Medicare capitation, FFS) ▪ Comprehensive prescription drug benefits in each option.

Retired CalSTRS members would benefit from a choice of plans, carriers and premium structures. This would enable each to select a program that most effectively meets their individual needs. The local plans would continue to establish their own health care benefits and administrative structure.

FUND INDIVIDUAL RETIRED MEMBER HEALTH BENEFIT PREMIUM PAYMENTS

Under this alternative, CalSTRS would provide a medical benefit equal to an amount of money based on years of service credited to CalSTRS. The funds would be directed by the retired member to pay for qualified health care costs. A health insurance premium support plan has the appeal of simplicity, and builds on CalSTRS traditional strengths of investment of contributions and the payment of fixed dollar benefits. Because CalSTRS does not have experience in the management and oversight of health insurance benefits, any program that requires CalSTRS to be a health plan sponsor would introduce new roles to the organization. However, a plan that requires CalSTRS to manage payments on behalf of the member would be consistent with core competencies and strengths.

A simple plan to understand.

A plan easy to administer.

Plan maximizes the strengths of CalSTRS core competencies.

This plan does not attempt to introduce or encourage any change in the current school health insurance landscape. Because of the history of health insurance for retired employees in schools and the diversity of circumstances among CalSTRS retired members, the one option clearly workable for all retired members is to provide financial support for the choices each individual has made and will continue to make. Diversity of health care circumstances among current retired members makes finding a health benefit plan that is of strong interest to all a challenge.

KEY POINTS

- A CalSTRS benefit paid on behalf of each retired member directly to the health insurer of their choice is the one plan in which nearly 100 percent of all retired members would find valuable.
- One of the health insurers could be the Medicare system for Part B, Medical Insurance coverage. Nearly 100 percent of retired CalSTRS members must purchase Medicare Part B.
- Funding could be available to support a very limited number of entities, or broadened to include any qualified medical expense.

Plan Cost Estimate: Using the Medicare Part B premium as a monthly benefit benchmark, preliminary estimates indicate that this plan would cost $573 million over 10 years (if only members with 15 years of service credit could participate), assuming the plan would not pay any premium surcharges for those who have not enrolled in Medicare Part B when first eligible. Such a plan would provide a health insurance contribution designated specifically to reducing the financial burden of retirement medical expenses.

10-Year benefit Projection
(in millions)

25 Yrs/Service	$290
20 Yrs/Service	$490
15 Yrs/Service	$573

The member would not have the option to take cash payments, and the benefit would be paid directly to the insurance provider. The benefit should not be subject to federal income tax.

Adding district plans and other insurers would expand the usefulness of the plan.

Plan Design: The use of benefits under this alternative could be limited to a specific health benefit, or widened to include any qualified medical expense:

1. Limited use: CalSTRS has established an effective working relationship as a group payer with the Health Care Financing Administration through the implementation of the Medicare Part A benefit. That relationship could be expanded to include payment of retired members' Part B premiums. Because the administrative capabilities are already in place, adding Part B payments would be a smooth implementation. For members whose Part B premiums are paid from any Social Security benefit checks they may be receiving, CalSTRS would reimburse the member directly for the premium payment.

2. Broad use: Alternatively, this option could be expanded to include payments to insurance carriers in addition to Medicare Part B. Some members have Part B premiums deducted from their monthly Social Security check. Under this option, the member could have the CalSTRS benefit paid directly to their Medicare supplement insurance carrier. CalSTRS would make the benefit payments from the Teachers' Health Benefits Fund to the insurance provider within the scope of the plan provisions and could deduct any premium balance from the member's monthly benefit as an added service. Some examples of additional eligible payees may be Kaiser Permanente's Senior Advantage Medicare+Choice plan; Blue Cross of California Medigap plans; California Blue Shield; and all local district health plans. Ultimately, this alternative could provide reimbursement for certain other eligible medical expenses, such as those for dental or vision care, which are not covered by a member's other plans.

ADMINISTER RETIREMENT HEALTH CARE SECURITY ACCOUNTS

This proposal is an innovative approach that would create a permanent source of funding for future CalSTRS retirees' health insurance premiums. While an active educator, members would have contributed on their behalf a small amount each month to the THBF that would earn investment income and be available for the payment of health care expenses after retirement. Such contributions could be paid by the state, CalSTRS, the employer or, indirectly, the member.

This plan would enable active CalSTRS members to begin taking concrete steps toward accumulating financial resources specifically designated to help pay for the cost of medical insurance after retirement. Because this alternative relies on small contributions paid while employed, it will require years before the amount available for any future retiree would be adequate to provide real help for retirement health care expenses. Those currently nearing retirement will not have time

Current Internal Revenue Service rulings do not allow the plan to be structured exactly as desired. Yet the concept is viable and highly desirable.

to accumulate enough in these accounts to provide security. Nonetheless, combining this program with one or more of the previous alternatives would establish a sound long-term retirement health care solution.

The pre-funded health contributions would be deposited into an individual nominal account that the member would use to pay health care costs upon retirement or upon reaching normal retirement age (for those who withdraw from CalSTRS pension benefits and leave education). The information currently available to CalSTRS indicates that the contributions must be determined either by statute on a statewide basis, or on a district-by-district basis through collective bargaining. Discussions with member organizations indicate that providing an opportunity for individual members to determine how much could be contributed to their accounts would enhance the viability of such a program. Assuming that CalSTRS' current understanding is correct, there would need to be changes made to federal law to provide such flexibility.

KEY POINTS

- The plan would help members accumulate funds during their working life to help offset the cost of health care in retirement.
- Ideally the contributions can be made on a pre-tax basis and accumulate without taxation.
- Through collective bargaining, districts and bargaining units could establish parameters for district contributions.

ISSUES TO CONSIDER

- Current Internal Revenue Codes and Rulings place several restrictions on plan design that are not desirable.
  - Contributions must be designated as employer money and therefore, are not available to the member until retirement.
  - Individual employees have no discretion on participation or the amount contributed.
- Implementation of this plan option would be lengthy.
- In order for the plan to be of most value, changes in federal law would be required.

Plan Cost Estimate: After plan installation, administrative activities would be very similar to those currently performed for three other CalSTRS programs (the Defined Benefit Supplement, the Cash Balance Benefit, and the Medicare Benefits Programs). The activities required include receipt of member and district contributions, investment of funds, member account value tracking, and payment of health insurance premiums to designated entities. On-going administrative expenses should be relatively nominal.

Administrative requirements of this plan are consistent with CalSTRS core competencies.

Implementation tasks will be complex and will take more than a year to complete.

Start-up costs could be expected to run near $2 million over an 18-month period. An outside administrative entity could perform most of the ministerial aspects of the plan. It may be possible to secure technology needs on a pay-as-you-go contract from an experienced vendor. Regardless of the choice of in-house operations or contracting out, this plan would require a substantial administrative effort to launch.

Plan Design Table:

ILLUSTRATIVE BENEFIT DESIGN
HEALTH CARE SECURITY ACCOUNTS

1. Each participating member would have a unique nominal account for reporting and tracking purposes.
2. In order for the contributions to be made on a pretax basis, the member would have neither choice of participation nor choice of the amount (percentage) contributed. All members of the group would participate on an identical basis.
3. The participation group can be defined as (1) all members statewide or (2) each individual district could be its own 'group' with the plan being implemented on a district-by-district basis.
4. Contributions could be vested immediately, but would not be available to the member until (1) retirement from CalSTRS or (2) normal CalSTRS retirement age. (Members who withdrew from the retirement system would not be able to receive any refunds of contributions, but would be able to collect benefit payments upon reaching normal CalSTRS retirement age.)
5. Varying the amount of the member's contribution based on length of service MAY meet the IRS criteria and other tax tests as long as all members with similar length of service contribute the same amount or percentage of salary.
6. Any contributions made on behalf of the member from any source would not be available to the member prior to retirement or death.
7. Investment growth from the member's contributions would not be vested until retirement from CalSTRS.
8. Individual members would not select investment vehicle(s). All member accounts would be aggregated for investment purposes.
9. Any undistributed funds (due to the death of the member, for example) could be redistributed to other program participants.

CONCLUSION AND RECOMMENDATION

Although active California public school educators have near universal access to affordable health care, the availability of affordable health care for retired educators, particularly those over age 65, is substantially more variable. Over 75 percent of retired CalSTRS members over age 65 receive little or no financial support of their health care needs from their prior employers. Beginning this year, CalSTRS is implementing a program to provide retired members a means by which they can secure hospitalization coverage through Medicare, without having to pay a monthly premium. However, such coverage, while very important, does not provide comprehensive coverage of the needs of retired members. Medicare does not cover prescription drugs, and members have to acquire Medicare supplement coverage to obtain such coverage and reduce the cost of other health care.

There are means available for retired CalSTRS members to obtain additional financial support for their health care needs. Such programs can provide comprehensive coverage or more targeted coverage, such as catastrophic prescription drug insurance or the payment of Medicare Part B premiums. In addition, mechanisms could be established to provide a tax-favorable means for active members to accumulate funds while working that would be available to pay health care costs in retirement.

The issue that confronts the CalSTRS membership and the Board, and ultimately the Legislature and the Governor is one of establishing priorities. Assuming that there is a consensus that CalSTRS should participate, in some way, in attempting to address the problem of providing affordable access to health care, the various parties need to determine the extent to which the priority for such a program is greater or lesser than the priority for increases in CalSTRS pension benefits. In addition, the resources currently available to CalSTRS are not sufficient to completely offset the cost of any such program. Consequently, one or more other parties, be it the members, the employer or the state, would have to provide additional resources, either in the form of premiums or increased contributions to CalSTRS.

In general, the CalSTRS membership, speaking through the organizations representing CalSTRS members, believes that a CalSTRS program to support health care for retired members would be valuable. At this time, however, no consensus has been reached among the different organizations which specific health benefit program should receive the highest priority for implementation.

CalSTRS' review of the health benefit environment indicates that there is a need for specific improvements to the health benefits provided to retired CalSTRS members. In particular, the availability of affordable comprehensive care to members over age 65 is, to a large degree, dependent on the coverage provided by their former employer, which varies substantially across the state.

In light of that need, the Board recommends that the Legislature, subject to the availability of resources to CalSTRS and no increased General Fund contributions, enact legislation that

1. Establishes a prescription drug plan that covers prescription drug costs above a specified level to provide catastrophic coverage for retired members, and
2. Establishes individual nominal health benefit accounts for retired members, with CalSTRS contributions credited to the accounts to pay Medicare Part B premiums, or an equivalent subsidy.

In addition, CalSTRS' review of alternative health benefit programs indicated that crediting contributions into individual nominal health benefit accounts while members are employed is a potential long-term solution to making affordable health care available to members when they retire in the future. As a result, the Board has directed CalSTRS staff to explore the legal and tax issues associated with establishing such accounts, and identify any necessary changes to federal law to facilitate development of this program.

Appendices

Appendix One	**Constituent Group Positions**
Appendix Two	**California Medigap and Medicare+Choice Plans**
Appendix Three	**Districts Contributions toward Retired Employee Health Insurance**
Appendix Four	**Other States Retired Members Health Care Funding Practices**

Constituent Group	Position: Surplus Funds for Retired member Health Care	Primary Benefit Choice	Acceptable Alternative(s)
ACCCA Association of California Community College Administrators	"CalSTRS should use limited retirement fund surpluses to provide a health insurance subsidy…"	Catastrophic Prescription Drug Plan	Menu of health insurance sources that CalSTRS would remit premium to on behalf of the retired member, if it included Medicare Part B as an option.
ACSA Association of California School Administrators	"ACSA is supportive of use of … excess earnings for retiree health care. This position assumes that any health care subsidies … will compete with other benefit enhancements when surplus funds are available."	Catastrophic Prescription Drug Plan	Supplemental Medicare medical coverage.
ART Association of Retired Teachers	"ART supports the concept of utilizing excess retirement funds for health benefits provided that it is done in a manner that provides a comparable benefit to teachers who already have retirement benefits paid for by their school districts." Currently ART only supports Senate Bill 191, (Karnette)	Menu of health care options that the member could select to have CalSTRS remit (such as fees or premiums) on behalf of the retired member. Medicare Part B should be one of the options available.	
CCAE Association of California Adult Education	Qualified support but concerned about long term funding. Do not want to reward districts that do not provide retired member health care benefits. Position paper not provided.	Catastrophic Prescription Drug Plan	A mechanism that will allow the pretax accumulation of funds to provide supplemental retirement benefits for health care with flexibility to meet other retirement needs.

Constituent Group	Position: Surplus Funds for Retired member Health Care	Primary Benefit Choice	Acceptable Alternative(s)
CFT California Federation of Teachers	Qualified support. Questions remain regarding amount of payment available, and other CFT retirement priorities. Position paper not provided.	Catastrophic Prescription Drug Plan	
CSBA California School Board Association	Unofficial support. State Board has not yet provided written notice. Position paper not provided.	Position on specific benefits not yet received.	
CRTA California Retired Teachers Association	Support the use of excess funds to improve retired members' ability to pay rising health care expenses. With wide differences in the need and circumstances of individual retired members, CRTA supports a plan that would provide personal options for each individual member.	Supports the concept of a CalSTRS retired member subsidy individual health care accounts. The member would select the best personal health care option. January 22, 2001 Position on the Catastrophic Prescription Drug Plan: Abstained from support or opposition.	
CTA California Teachers Association	"…recommend that the state use future STRS excess monies for a combination of benefits for active and retired STRS members."	Catastrophic Prescription Drug Plan	Active member retirement health accounts, (Pre-funding), IF, a mechanism can be found to allow flexibility on participation requirements and pretax contributions.

Constituent Group	Position: Surplus Funds for Retired member Health Care	Primary Benefit Choice	Acceptable Alternative(s)
CTA-R California Teachers Association, Retired	Support allocating some of the excess funding toward health care benefits for retired system members. Position paper not provided.	Catastrophic Prescription Drug Plan	
FACCC Faculty Association of California Community Colleges	Support use of excess funds for retired member medical benefits.	Catastrophic Prescription Drug Plan	Menu of health care sources that CalSTRS could remit premiums to on behalf of the retired member, if it included Medicare Part B as an option.
CVT Central Valley Trust	Support use of excess funds for retired member medical benefits.	Catastrophic Prescription Drug Plan	Any additional retiree benefit that does not provide an adverse cost impact to the Trust.
EGUSD Elk Grove Unified School District	Support funding for a minimum prescription drug plan.	Catastrophic Prescription Drug Plan	
LACCD LA Community College District	Qualified support. No position paper provided.	Catastrophic Prescription Drug Plan	
LACCG LA Community College Guild	Support use of excess funds for retired member health care.	Catastrophic Prescription Drug Plan	
LAUSD LA Unified School District	No position taken, at this time.	Does not support any benefit plan that requires CalSTRS to be a plan sponsor.	

Constituent Group	Position: Surplus Funds for Retired member Health Care	Primary Benefit Choice	Acceptable Alternative(s)
PCSIG Placer County Schools Insurance Group	Support use of excess funds for retired member health care.	Catastrophic Prescription Drug Plan	
SUSD Sacramento Unified School District	Support some funding for retired member health care. No position paper provided.	No position on specific benefits.	
UTLA United Teachers of Los Angeles	Support use of excess funds for retired member catastrophic prescription drug and/or pay part or all of Part B premiums.		
VEBA-SD Voluntary Employee Benefit Association of San Diego.	Qualified support secondary to using increases to "…bring all retirees to a living income."	Catastrophic Prescription Drug Plan	

Appendix Two
Medigap Plans and Premiums in Selected Counties
Premiums for a 65 Year Old Applicant

County/Plan	Blue Cross	Blue Shield	Central States	Conseco Direct	Bankers Life	Standard Life	GE Life	Monumental	CalFarm	United American
Sacramento County										
Plan F	86.00	85.00	94.00	100.83	123.41	117.41	140.00	153.00	135.33	137.00
Plan I		157.00			471.58			228.00		
Plan J	199.00						278.91	328.00	272.33	
Kern County										
Plan F	86.00	85.00	108.83	110.00	123.41	128.08	140.00	153.00	134.50	137.00
Plan I		157.00			471.58			228.00		
Plan J	199.00						278.91	328.00	271.50	
Fresno County										
Plan F	86.00	85.00	94.00	84.33	123.41	117.41	140.00	153.00	134.50	137.00
Plan I		157.00			471.58			228.00		
Plan J	199.00						278.91	328.00	271.50	
Los Angeles County										
Plan F	99.00	104.00	138.50	145.75	167.16	149.41	140.00	153.00	157.25	167.50
Plan I		186.00			651.25			228.00		
Plan J	199.00						278.91	328.00	318.16	
San Diego County										
Plan F	99.00	104.00	108.83	110.00	123.41	128.08	140.00	96.08	157.66	167.50
Plan I		186.00			471.58			228.00		
Plan J	199.00						278.91	328.00	318.58	
Shasta County										
Plan F	86.00	85.00	94.00	91.66	123.41	117.41	?	153.00	134.50	137.00

Appendix Two
Medicare+Choice HMO Availability
All California Counties

County	Aetna Golden Medicare (10 & 5)	Blue Cross Senior Secure	Blue Shield 65+	Health Net Seniority Plus	Inter Valley Health Plan	Kaiser Senior Advantage	MaxiCare Max Plus	PacifiCare Secure Horizons (Basic & Plus)	Regional Plans
Alameda									
Alpine	NO PLANS AVAILABLE								
Amador									
Butte									
Calaveras	NO PLANS AVAILABLE								
Colusa									
Contra Costa *									**Contra Costa Health Plan**
Del Norte	NO PLANS AVAILABLE								
El Dorado									**WHA**
Fresno									
Glenn	NO PLANS AVAILABLE								
Humboldt									
Imperial									
Inyo	NO PLANS AVAILABLE								
Kern									
Kings	NO PLANS AVAILABLE								
Lake									
Lassen									
Los Angeles									**Universal HC**
Madera									
Marin									

Appendix Two
Medicare+Choice HMO Availability
All California Counties

County	Aetna Golden Medicare (10 & 5)	Blue Cross Senior Secure	Blue Shield 65+	Health Net Seniority Plus	Inter Valley Health Plan	Kaiser Senior Advantage	MaxiCare Max Plus	PacifiCare Secure Horizons (Basic & Plus)	Regional Plans
Mariposa	NO PLANS AVAILABLE								
Mendocino									
Merced									
Modoc									
Mono									
Monterey									
Napa									
Nevada	NO PLANS AVAILABLE								
Orange									Universal Care
Placer									WHA
Plumas	NO PLANS AVAILABLE								
Riverside									Universal Care
Sacramento									WHA
San Benito	NO PLANS AVAILABLE								
San Bernardino									
San Diego									Sharp Health Plan
San Francisco									Chinese Community Health Plan
San Joaquin									
San Luis Obispo									
San Mateo									

Appendix Two
Medicare+Choice HMO Availability
All California Counties

County	Aetna Golden Medicare (10 & 5)	Blue Cross Senior Secure	Blue Shield 65+	Health Net Seniority Plus	Inter Valley Health Plan	Kaiser Senior Advantage	MaxiCare Max Plus	PacifiCare Secure Horizons (Basic & Plus)	Regional Plans
Santa Barbara									
Santa Clara									
Santa Cruz									
Shasta									
Sierra									
Siskiyou									
Solano									WHA
Sonoma									Health Plan of Redwoods
Stanislaus									
Sutter									
Tehema									
Trinity									
Tulare									
Tuolumne									
Ventura									
Yolo									WHA
Yuba									

KEY:

Available	Not Available	No HMO Plans	UNKNOWN

Appendix Three
Districts Contributions toward Retired Employee Health Insurance

Analysis of J-90 Report District Contribution Data

In 2000, the California Department of Education conducted a voluntary survey of all California K-12 school districts on teacher compensation and employee benefits. Over 800 districts provided information on the compensation and employee benefits. The data collected is comprehensive in all areas and is the broadest source of information on district provided health benefits developed to date. The information collected includes premiums for all carriers and all benefits. Enrollment is provided on each district's sponsored medical, dental, and vision plans by both active and retired employees. The district's annual contribution toward each benefit and each carrier is also included.

Unfortunately less than 600 districts provided information on the health care benefits provided to retirees. A possible assumption might be that if no retiree enrollment or district contributions were reported it was because none existed. Although reasonable, no such assumption was made. Without CalSTRS verifying the information, those districts that provided no data for retirees are simply excluded from the following conclusions

1. Under 65 Retired Employees

a. 62 % of districts contribute 100% of the premium for retired employees under 65
b. 11% of districts contribute 75% of the premium for retired employees under 65
c. 8% of districts contribute 50% of the premium for retired employees under 65
d. 19% of districts contribute less than 50% of the premium for retired employees under 65
e. 16% of districts do not contribute any portion of the premium for retired employees under 65

2. Over 65 Retired Employees

a. 38% of districts contribute 100% of the premium for retired employees over 65
b. 3% of districts contribute 75% of the premium for retired employees over 65
c. 4% of districts contribute 50% of the premium for retired employees over 65
d. 8% of districts contribute less than 50% of the premium for retired employees over 65
e. 48% of districts do not contribute any portion of the premium for retired employees over 65

Appendix Three
Districts Contributions toward Retired Employee Health Insurance

County	Study District Code	District Name	Number of Active Employees	Number of Retirees	Retirees Under-Age 65. Percentage of Premium Paid by District.	Retirees Over Age 65. Percentage of Premium Paid by District.	Limitation on Contribution
Alameda	75039	Dublin Unified			Provided No Retiree Data		
Alameda	61176	Fremont Unified			100%	0%	
Alameda	61192	Hayward Unified			100%	100%	To age 70
Alameda	75101	Pleasanton Unified			Provided No Retiree Health Data		Dental Only Paid
Amador	73981	Amador County Unified			62%	Less than 5%	
Contra Costa	61804	San Ramone Valley Unified			45%	100%	
Contra Costa	61754	Mt. Diablo Unified			100%	5%	
Fresno	62117	Clovis Unified			100%	100%	
Fresno	62166	Fresno Unified			100%	100%	
Kern	63321	Bakersfield City Elementary			100%	0%	
Kern	63529	Kern Union High			100%	0%	
Los Angeles	64212	ABC Unified			82%	82%	
Los Angeles	73437	Compton Unified			Provided No Retiree Data		
Los Angeles	73445	Hacienda LA Puente Unified				0%	
Los Angeles		Los Angeles Community College District			100%	100%	
Los Angeles	64725	Long Beach Unified			100%	100%	
Los Angeles	64733	Los Angeles Unified			100%	100%	

Appendix Three
Districts Contributions toward Retired Employee Health Insurance

County	Study District Code	District Name	Number of Active Employees	Number of Retirees	Retirees Under-Age 65. Percentage of Premium Paid by District.	Retirees Over Age 65. Percentage of Premium Paid by District.	Limitation on Contribution
Los Angeles	64808	Montebello Unified			100%	0%	To age 67
Los Angeles	64840	Norwalk - LA Mirada Unified			0%	0%	
Los Angeles	64857	Palmdale Elementary			100%	100%	To age 70
Los Angeles	64881	Pasadena Unified			69%	0%	
Los Angeles	65060	Torrance Unified			0%	0%	
Marin	65466	San Rafael City High			0%	0%	
Orange	66431	Anaheim Union High			80%	6%	
Orange	66464	Capistrano Unified			100%	0%	
Orange	66522	Garden Grove Unified			95%	0%	
Orange	64568	Glendale Unified			100%	0%	
Orange	73650	Irvine Unified			100%	0%	
Orange	66597	Newport-Mesa Unified			53%	0%	
Orange	66621	Orange Unified			100%	100%	
Orange	66647	Placentia-Yorba Linda Unified			93%	93%	
Orange	73635	Saddleback Valley Unified			100%	0%	
Orange	66670	Santa Ana Unified			100%	100%	
Riverside	67033	Corona Norco Unified			100%	100%	
Riverside	67058	Desert Sands Unified			100%	0%	
Riverside	67124	Moreno Valley Unified			100%	0%	
Riverside	67215	Riverside Unified			100%	0%	

Appendix Three
Districts Contributions toward Retired Employee Health Insurance

County	Study District Code	District Name	Number of Active Employees	Number of Retirees	Retirees Under-Age 65. Percentage of Premium Paid by District.	Retirees Over Age 65. Percentage of Premium Paid by District.	Limitation on Contribution
Riverside	68411	Sweetwater Union High			72%	0%	
Sacramento	67314	Elk Grove Unified			86%	86%	Instituted Prefunding in 1993
Sacramento	67439	Sacramento City Unified			100%	100%	
Sacramento	67447	San Juan Unified			74%	0%	
San Bernardino	67678	Chino Valley Unified			100%	0%	
San Bernardino	67686	Colton Joint Unified			100%	0%	
San Bernardino	67710	Fontana Unified			100%	100%	
San Bernardino	67819	Ontario-Montclair			100%	0%	
San Bernardino	64907	Pomona Unified			50%	0%	
San Bernardino	67850	Rialto Unified			100%	0%	
San Bernardino	67876	San Bernardino City Unified			100%	100%	Five years only
San Bernardino	61796	West Contra Costa Unified			82%	88%	
San Diego	68023	Chula Vista Elementary			100%	0%	
San Diego	73569	Oceanside City Unified			31%	0%	
San Diego	68296	Poway Unified			85%	0%	
San Diego	68338	San Diego City Unified			27%	36%	To age 67
San Diego	68452	Vista Unified			59%	82%	To age 68
San Francisco	68478	San Francisco Unified			100%	100%	Retiree Only
San Joaquin	68585	Lodi Unified			84%	0%	

Appendix Three
Districts Contributions toward Retired Employee Health Insurance

County	Study District Code	District Name	Number of Active Employees	Number of Retirees	Retirees Under-Age 65. Percentage of Premium Paid by District.	Retirees Over Age 65. Percentage of Premium Paid by District.	Limitation on Contribution
San Joaquin	68676	Stockton Unified			42%	37%	
San Joaquin	75499	Tracy Joint Unified			100%	N/R	
San Joaquin	71308	Turlock Joint Elementary			0%	0%	
San Mateo	68916	Jefferson Elementary			Provided No Retiree Data		
San Mateo	69047	San Mateo Union High			100%	91%	
Santa Barbara	69120	Santa Maria Bonita			100%	0%	
Santa Clara	69666	San Jose Unified			44%	85%	
Santa Cruz	69799	Pajaro Valley Unified			100%	0%	
Shasta	70136	Shasta Union High			100%	N/R	
Solano	70540	Fairfield-Suisun Unified			50%	Less than 5%	
Solano	70581	Vallejo City Unified			100%	100%	
Stanislaus	40717	Modesto City			Less than 5%	Less than 5%	
Tulare	72256	Visalia Unified			100%	0%	

Appendix Four
Other States Health Care Funding Practices

Original Survey Conducted April 1999
Compiled Information Updated February 2001
Source: National Education Association's Rankings of the States, 1999

During the month of February 2001, a telephone survey was conducted to obtain the information summarized in the accompanying table regarding retired teachers' health benefits in selected states. The states were surveyed based on their salary comparability, size, and /or proximity to California.

State	Average Teacher Salary [1]	Method of Providing Retired Teachers Health Care Benefits	Number of Retired Teachers	Prescription Drug Benefit (Statewide Plans)	Over Age 65 Premium Rates:	Method of Funding Health Benefits and Amount	Program Costs:
Connecticut	$51,584						
New Jersey	$51,193	Generally administered at district level. Retirees with 25+ years of service participate in statewide plan. Districts may also elect to participate in the statewide plan	41,000 covered at state expense	Comprehensive $300 annual out-of-pocket max. 3 Tier co-pay. No annual benefit max.	Medicare Retiree Indemnity - $198.57 HMO - $161.82 - $204.47 Non-Medicare Retiree Indemnity - $342.85 HMO - $239.08- $279.89	Participants in district plans pay group rates. State makes allocation to the Teachers' Pension and Annuity Fund to provide full coverage for retirees with 25+ years of service. No subsidy for those with less than 25 years of service.	N/A

Appendix Four
Other States Health Care Funding Practices

State	Average Teacher Salary [1]	Method of Providing Retired Teachers Health Care Benefits	Number of Retired Teachers	Prescription Drug Benefit (Statewide Plans)	Over Age 65 Premium Rates:	Method of Funding Health Benefits and Amount	Program Costs:
New York	$49,437	Generally administered at district level. Districts must cover retirees if they cover actives. Districts may elect to participate in a statewide plan (few do)	110,000 Statewide NYC - N/A	Varies according to district.	Varies according to district.	Negotiated at individual district level.	N/A
Pennsylvania	$48,457	Statewide (PSERS Health Options Program) and local district plans		Comprehensive High option and standard option plans. $250 or $500 deductibles with 20% or 50% co-pays. both have 2 tier mail order co-pay	Premiums vary depending on plan type (Indemnity, HMO) and retiree's Medicare status	Tax-free premium assistance of up to $55/mo for statewide and local district plans. requires 24 and one-half years of service or 15 years and retirement on or after age 62.	
Michigan	$48,207	Statewide plan	120,000	Comprehensive *Formulary* - 20% co-pay with $750 per year out-of-pocket max. *Non-Formulary* - 40% co-pay with no per year out-	Medicare Retiree $225.82 Non-Medicare Retiree $467.74	Subsidy Medicare Retiree $225.82 Non-Medicare Retiree $417.74	FY 2000 *Medical* Non-Medicare $106.5M Medicare $70.1M *RX*

Appendix Four
Other States Health Care Funding Practices

State	Average Teacher Salary [1]	Method of Providing Retired Teachers Health Care Benefits	Number of Retired Teachers	Prescription Drug Benefit (Statewide Plans)	Over Age 65 Premium Rates:	Method of Funding Health Benefits and Amount	Program Costs:
				of-pocket max.			Non-Medicare $45.3M Medicare $113.2M
Alaska	$46,845	Statewide plan			Retirees hired prior to 7/1/90, or after 6/30/90 if at least age 65+ - no premium Retirees hired after 6/30/90 under age 60 - full premium ($410) Retirees hired after 6/30/90 over age 60 and under 65 - 1/2 premium.($205)		FY 2000 *Medical* $40.2M.
Rhode Island	$45,650	Generally administered at district or municipal level. Retirees may participate in	6,000	Not available in indemnity plan. Comprehensive in Medicare+Choice plans $500 max.	(Statewide Plans) Medicare Retiree Indemnity - $114.46 HMOs- $46.00-	Negotiated at individual district level. No subsidy for teachers in statewide	N/A

Appendix Four
Other States Health Care Funding Practices

State	Average Teacher Salary [1]	Method of Providing Retired Teachers Health Care Benefits	Number of Retired Teachers	Prescription Drug Benefit (Statewide Plans)	Over Age 65 Premium Rates:	Method of Funding Health Benefits and Amount	Program Costs:
		statewide plan if not covered by district. (Few in this category)		annual benefit.	$49.00	plan System negotiates with carriers for group rates	
California	$45,400						
Oregon	$42,833	Local Districts to age 65. After 65 or when Medicare eligible, retirees can participate in PERS		Comprehensive Pays 50% of drug costs up to $150 out-of pocket max. No annual max. benefit.	Medicare Retiree: Medicare+Choice - $89.33 to $121.09 Kaiser - $96.03 Indemnity - $131.19	System subsidizes premium @$60/mo. for retirees with at least 8 years of service. Subsidy is assessed against district teacher retires from.	N/A
United States	$40,582						
Nevada	$38,883	Most retirees have choice of district plans or state plan. 99.9% stay on district plans due to better benefits. Retirees not continued by districts may join statewide plan	Washoe County 1200	Washoe County $25 annual deductible 2 Tier co-pay No annual maximum benefit.	Washoe County PPO $301 EPO $301 Clark County PPO and HMO rates are approx. $300/mo.	Washoe County District subsidizes up to 40% of premium depending on years of service. No subsidy for statewide plan unless provided by districts (few do) Clark County No district subsidy	N/A
Washington	$38,692	District plan provided to actives only. Retirees must	19,000	Comprehensive $100/$300 deductible	Medicare $69.49 - $195.33 (after state	Retiree premiums and state funded contribution of	N/A

Appendix Four
Other States Health Care Funding Practices

State	Average Teacher Salary [1]	Method of Providing Retired Teachers Health Care Benefits	Number of Retired Teachers	Prescription Drug Benefit (Statewide Plans)	Over Age 65 Premium Rates:	Method of Funding Health Benefits and Amount	Program Costs:
		enroll in statewide public employee plan. Retirees must enroll in Medicare if eligible.		3 Tier co-pay Mail order available	contribution) <u>Non-Medicare</u> $209.40 - $240.00	$69.98/mo. toward Medicare rates.	
Colorado	$38,025	Statewide HMO, POS, and PPO plans Employer participation optional.			Premiums vary depending plan type (Indemnity, PPO, HMO) and retiree's Medicare status	Subsidy for pre-Medicare retirees - up to $230/mo Subsidy for Medicare retirees - up to $115/mo Percent of subsidy is based on years of service at rate of 5% per year	
Texas	$35,041	Statewide plans are available for retirees with 10+ years of service. No other coverage provided.	109,000 covered	<u>TRS-CARE 3 Plan</u> Only plan with Rx benefit 2 Tier co-pay plus Difference between generic and brand name costs	TRS-CARE 1 Medicare - N/A Non-Medicare -$0 TRS-CARE 2 Medicare - $0 Non-Medicare - $48.00 TRS-CARE 3 Medicare - $67.00 Non-Medicare - $162.00	❑ State contribution, ❑ Active contribution (.25% salary) ❑ Retiree premium ❑ Investment earnings	To be e-mailed

Appendix Four
Other States Health Care Funding Practices

State	Average Teacher Salary [1]	Method of Providing Retired Teachers Health Care Benefits	Number of Retired Teachers	Prescription Drug Benefit (Statewide Plans)	Over Age 65 Premium Rates:	Method of Funding Health Benefits and Amount	Program Costs:
Arizona	$35,025	Statewide Plan with Indemnity, PPO, and HMO options.			Premiums vary depending on county of residence and plan type (HMO, PPO, Indemnity)	Subsidy of 50% to 100% of premium depending on years of credited service (5.0-10+)	